














Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_  
 Insurance ID #: \_\_\_\_\_ Name of Plan/Insurance: \_\_\_\_\_

Does patient have Gestational Diabetes? ☐ Yes or ☐ No EDC Date: \_\_\_\_\_ ( ) DO NOT SEND METER

Diabetes: ☐ Type 1 ☐ Type 2 Does patient use insulin? ☐ Yes or ☐ No Gender: M ☐ F ☐

## Meter

 ( ) Compact	 <input type="checkbox"/> One Touch Ultra Mini <input type="checkbox"/> Pink <input type="checkbox"/> Green <input type="checkbox"/> Blue <input type="checkbox"/> Silver <input type="checkbox"/> Black <input type="checkbox"/> Purple	True Result Meter <input type="checkbox"/>	 ( ) Contour	 <input type="checkbox"/> Prodigy <input type="checkbox"/> Prodigy AutoCode <input type="checkbox"/> Prodigy Voice
 <input type="checkbox"/> One Touch Ultra-2	 ( ) Freestyle-Life	 ( ) Freedom-Life	<input type="checkbox"/> True-Track 	
 ( ) Aviva	 <input type="checkbox"/> One Touch Ultra	 ( ) Precision Xtra	 ( ) Breeze-2	 ( ) NovaMax

## Test Strips

\_\_\_\_ #200 / #204 - Testing 6 to 8 times daily or as needed  
 \_\_\_\_ #150 / #153 - Testing 4 to 5 times daily or as needed  
 \_\_\_\_ #100 / #102 - Testing 2 to 3 times daily or as needed  
 \_\_\_\_ #50 / #51 - Testing 1 time daily or as needed

## Lancets

\_\_\_\_ #200 / #204 - Testing 4 to 8 times daily or as needed  
 \_\_\_\_ #100 / #102 - Testing 2 to 3 times daily or as needed

Qty: 30 Days supply

Other Insulin: Type \_\_\_\_\_ Qty: 30 Days supply  
 Supplies Directions: \_\_\_\_\_

Syringes: ☐ 1ml ☐ 1/2ml ☐ 3/10 Qty: 30 Days supply  
 # \_\_\_\_\_ Injections per day  
 Directions: \_\_\_\_\_

Ketostix: ☐ 50 ☐ 100 Qty: 30 Days supply  
 Directions: \_\_\_\_\_

☐ Glucagon Kit; Directions: \_\_\_\_\_

Notes:

Refills Authorized: ☐ PRN 1 year ☐ # \_\_\_\_\_ Refill until 1 month after EDC date of: \_\_\_\_\_

I hereby certify that the following service, blood glucose test strips and lancets, are medically necessary for this Patient \_\_\_\_\_ (name) on this date of service: \_\_\_\_\_ (date)

For the following reasons (circle): Diabetes Mellitus Type 1, DM Type 2, and Gestational Diabetes.

Physician Name: \_\_\_\_\_ MD (Required) Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ MD (Required)

DEA #: \_\_\_\_\_ State Lic #: \_\_\_\_\_ NPI #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Fax: \_\_\_\_\_

Diabetes Educator/Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

Ordering/Authorizing signature: \_\_\_\_\_ PA / RN / CDE / RD (Required)

Please send my diabetes supplies on a monthly basis based on my current need. If my use of the testing Supplies changes I will notify Mini Pharmacy so my shipment can be adjusted.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Fax to 1-800-280-2939**